Authorization to Administer Medication at School, School Sponsored Events, Field Trips

This document must be completed by a **PHYSICIAN WITH PRESCRIPTIVE AUTHORITY** for both **over the counter** and prescription medications. Physician's name must be clearly printed below.

Student's Name: _____

Medication: _____

Dosage: _____Route:_____
(PLEASE BE SPECIFIC)

Time(s) of day medication is to be given: _____
(PLEASE BE SPECIFIC)
Anticipated Duration of need: _____

Purpose of Medication: _____

Special Instructions: _____

Possible Side Effects: _____

Print Prescribing Healthcare Provider's Name: _____

Phone Number of Prescribing Healthcare Provider::_____

_____ _____
Signature of Health Care provider with Prescriptive Authority **Date**

Parent/Legal Guardian Name/Phone number: _____

_____

I hereby give my permission for the above listed medication(s) to be dispensed to my child by school personnel as prescribed. I release the school from any responsibility for side effects or other medical consequences of this medication. It is my responsibility to furnish the medication in the original labeled container. I agree to pick up and replace expired or unused medication within one week of notification by school staff.

_____ _____
Signature of Parent/Legal Guardian **Date**

Durango Montessori School agrees to administer the above medication as prescribed by the licensed healthcare provider. Prescription medications must be provided to the school in an original pharmacy labeled container with child's name, name of medication, time medication is to be given, dosage, date and licensed health care provider's name. Ask the pharmacist for a separate medicine bottle to keep at school if necessary. All over the counter (FDA approved) medications must be labeled with child's name and be in original manufacturer's packaging. Dosage must match the signed licensed health care provider's authorization.

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